9031

THURSDAY, JANUARY 16, 2003

(Afternoon Session Continued)

---o0o---

THE COURT: Okay. Bring the jury in.

(The jurors are brought in at 3:15 pm.)

THE COURT: Okay, proceed.

Dim the lights, please.

(The videotaped deposition of Ketan C. Mehta, M.D., is continued to be played.)

Q. BY MR. BROWN: And, Doctor, I've handed you, Bates No. 2010480040064, which said the medical records at the top, again, from Laurence Lucier.

Do you see that?

A. Yes.

Q. And the date in there, if you can see it, is 6/15/99, do you see that?

A. Yes.

Q. And this is the results of urine tests. Is that right?

A. Yes.

Q. And if you look over at the right-hand corner, they give some results from the urinalysis?

A. Yes.

Q. And the one that I wanted to ask you about was occult blood. Do you see that?

A. Yes.

Q. And the letters "M-O-D". are there?

A. "Moderate".

9032

Q. "Moderate". So this indicates that Mr. Lucier had some occult blood in his urine?

A. Yes.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

4 Q. That's hematuria?

5 A. Yes.

6 Q. Does that hematuria, when combined with the fact that

7 you noted a small hypodensity in the posterior left kidney

8 mean anything to you?

9 A. Probably the infarction of the kidney created some

10 blood spilling in the urine, and that is why the blood --

11 the urine test turned out to be positive for the blood.

12 Q. Could it also be tumor that would create the

13 hematuria?

14 A. Possibly.

15 Q. Doctor, before we segue to Dr. O'Neil's records, we

16 were going through Exhibit 8, which was the first page of

17 Dr. Collins's notes. And I had a couple more questions

18 about that.

19 A. Sure.

20 Q. After we get over that sentence about the fever,

21 there's a sentence that notes: "More recently he has lost

22 about 15 to 20 pounds, although this has been

23 semi-purposeful -- Purposefully."

24 Do you see that?

25 A. Right.

26 Q. Do you recall Mr. Lucier reporting a weight loss when

27 he presented to you in June of 1999?

28 A. I don't recall that.

9033

1 Q. The next sentence is: "He does have sweats at night

2 that required him to change the bedclothes."

3 Do you see that?

4 A. Yes.

5 Q. Now, I want you to move down further on Dr. Collins's

6 notes, I guess it is, Exhibit 8 --

7 A. Okay.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

8 Q. -- Where I guess it's -- She talks about the CT
9 scan of the chest.
10 A. Um-hum.
11 Q. Well, first of all, let's move up a little bit and
12 talk about the CT scan of the abdomen and pelvis.
13 Do you see that?
14 A. Yes.
15 Q. And she notes that "it showed hypodensity in the
16 spleen, most likely splenic infarcts, small hypodensity in
17 the posterior left kidney that may be a small infarct and a
18 left renal cyst."
19 Do you see that?
20 A. Yes.
21 Q. And that's consistent with what we read from your
22 report as well?
23 A. Yes.
24 Q. Do you remember? Except the renal cyst is something
25 that's additional, correct?
26 A. Yes.
27 Q. She goes on to say, "The differential of these things
28 will be tumor embolism."
9034
1 Do you see that?
2 A. Correct.
3 Q. Do you know what that means?
4 A. That tumor traveled or traveled from a point of
5 origin through blood vessels to other parts of the body.
6 Q. And in this case --
7 A. And then it creates like a seed or nidus, and it
8 grows and gets bigger.
9 Q. So in this case it would have traveled to the spleen
10 and to the kidney?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

11 A. Correct.

12 Q. Do you see the next sentence? She says, "Also these

13 lesions could conceivably" -- And she has in quotes --

14 "Represent lymphoma within the spleen."

15 Do you see that?

16 A. Correct.

17 Q. What's lymphoma within the spleen?

18 A. Oh, lymphoma is a diagnosis related to lymph glands,

19 and the spleen is a lymph gland essentially, a big lymph

20 gland.

21 Q. So a the spleen is one of the glands where a lymphoma

22 can develop?

23 A. Correct.

24 Q. And then she goes on and talks about a CT scan of the

25 chest, which shows a three-by-four centimeter right hilar

26 mass, and extensive pretracheal and subcarinal adenopathy;

27 we talked about that?

28 A. Yes.

9035

1 Q. And we talked about that already?

2 A. Yes.

3 Q. But she goes on to say, "No primary lung lesion."

4 Do you see that?

5 A. Correct.

6 Q. Now you didn't mention that in your report, but do

7 you agree with Dr. Collins that you didn't found any primary

8 lung lesions on that CT?

9 A. In the substance of the lung in the report, there was

10 no tumor seen.

11 MR. BROWN: What was that?

12 THE WITNESS: In the substance of the lung, like in

13 the lung substance, there was no tumor seen on the CAT scan.

14 Q. BY MR. MURPHY: Doctor, I've handed you what we've

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

15 marked as Exhibit 11 to the deposition. And for the record

16 it's got Bates No. 201048004-0024 through -0033, and I'll

17 state that I tried to make this a copy of the progress notes

18 for Mr. Lucier from when he was hospitalized in June of

19 1999. And I think the dates include 6/16/99 through 6/22.

20 Do you see that, doctor?

21 A. Yes.

22 Q. And why don't you -- If you could, first tell me

23 generally, what are progress notes?

24 A. It's going to -- After the initial evaluation as

25 things develop with the patient, you just write, you know,

26 hand-write.

27 Q. And whoever sees the patient would fill in the

28 progress notes chart?

9036

1 A. Correct.

2 Q. What I'm getting at is: You didn't write each of

3 those notes?

4 A. It will be various people -- People -- Medical

5 people coming in on a daily basis and writing the note.

6 Q. And so you did write some of them but not all of

7 them?

8 A. Correct.

9 Q. The one that I wanted to refer you to was on the

10 third page of Exhibit 11. The Bates number ends in -0026.

11 A. Okay.

12 Q. And it's an entry. It's the one at the bottom there

13 for 6/17/99, and it has 8:30 p.m.

14 A. Um-hum.

15 Q. Do you see that? And it's one entry, and it looks

16 like at the bottom that it has your signature there; is that

17 correct?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

18 A. Yes.

19 Q. Is that right?

20 A. Correct.

21 Q. So you made this entry for 6/17/99, 8:30 p.m.?

22 A. Correct.

23 Q. And maybe just read along on it and see where I have

24 a question. But it says, "Patient seen, examined, long

25 discussions. Case discussed" -- Is it with doctor -- I

26 want to say Soloman?

27 A. Right.

28 Q. Dr. Pearson?

9037

1 A. Yes.

2 Q. Dr. Gerson?

3 A. Yes.

4 Q. Dr. -- I can't read that one?

5 A. Showl.

6 Q. Dr. Showl, Dr. Chung and Dr. Collins.

7 Do you see that?

8 A. Correct.

9 Q. So what happened here, you met with these other

10 physicians, and you discussed Mr. Lucier's case?

11 A. Yes.

12 Q. And then you have a dash there. And it says

13 "lymphoma, versus", it looks like "lung cancer" --

14 "small-cell type".

15 Do you see that?

16 A. Correct.

17 Q. So at this point in time did you come to a

18 differential diagnosis that what you had seen there in the

19 hilum on x-ray was most likely either lymphoma or small-cell

20 lung cancer?

21 A. Maybe, because of the way, you know, it was spread in

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

22 the spleen, which is a lymph gland.

23 Q. You're anticipating my next question, and that was

24 going to be: What factors would have supported a

25 differential diagnosis of lymphoma at that point?

26 A. Because tumor was more central and possibly involving

27 spleen, and also there were a lot of nodes in the

28 mediastinum. So lymphoma may have nodes all over and

9038

1 involvement of the spleen, so -- And consider something

2 like lymphoma.

3 Also, patient had some low-grade fever history now

4 going back to, you know, our earlier discussion.

5 Q. And what factors supported that differential

6 diagnosis?

7 A. Well, mainly, you know, hilar-area lymph nodes,

8 pretracheal and subcarinal area lymph nodes and involvement

9 of the spleen and involvement of the, you know, other

10 organs. You think that maybe does patient have, like,

11 lymphoma or small-cell carcinoma, because it is rapidly

12 growing.

13 Q. Small cell is one of the four major cell types of

14 lung cancer?

15 A. Yes.

16 Q. And is it the rapid growth of the tumor that made you

17 think this was, as a differential diagnosis, potentially

18 small-cell rather than any of the other three types?

19 A. To some extent, because the CAT scan did not show

20 tumor in the substance of the lung, but it was more hilar

21 mediastinal. That was the reason.

22 Q. For an adenocarcinoma it would be more likely for a

23 CAT scan to show tumor in the substance of the lung.

24 Is that right?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

25 A. Always, yeah.

26 Q. Always it does.

27 How about for a large cell? It usually shows tumor

28 in the substance of the lung?

9039

1 A. Usually but it's not a very common cancer like

2 adenocarcinoma.

3 Q. Okay. Large cell is more rare than adenocarcinoma?

4 A. Correct. Adenocarcinoma will be about like 45

5 percent, and squamous cell would be like about 30 percent.

6 Small-cell would be about 20 percent, and the rest

7 will be large-cell or undifferentiated type.

8 Q. And do squamous cells usually present in the

9 substance of the lung also?

10 A. It will be present in -- Within the bronchi or, you

11 know, the bronchus, trachea or where the air pipes are, you

12 know, tubes are. But it will also be in the substance of

13 the lung at some point

14 Q. And because there was no tumor identified in the

15 substance of the lung, you thought at that point in time

16 that this was more likely a small-cell than any of those

17 other cell types?

18 A. Various factors probably played a key role in writing

19 that. It doesn't mean it was a final diagnosis.

20 Q. Okay. Now, eventually -- Well, let's get this

21 straight. Once you saw Mr. Lucier, he became your patient;

22 is that right?

23 A. Correct.

24 Q. You guided him through his stay at Santa Rosa at that

25 point in time, and his eventual diagnosis with cancer?

26 Is that right?

27 A. Yes.

28 Q. Do you remember the procedures that were undertaken

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

9040

on Mr. Lucier in order to diagnose cancer?

A. He did get bronchoscopy and transbronchial biopsies. And it's possible that I was off, so Dr. Kenneth Lamb seemed to have carried out that procedure of bronchoscopy.

Q. Okay.

A. And then I believe that Dr. Eric Chung had done the mediastinoscopy. And it seems that the mediastinoscopy gave the tissue that make the diagnosis of cancer.

Q. Well, let break that down a little bit.

First, Mr. Lucier had a bronchoscopy?

A. Yes.

Q. And the reason that you did a bronchoscopy first was because it was, it's less invasive than a mediastinoscopy?

A. Yes.

Q. And when you do a bronchoscopy, you're actually putting a scope into a patient's lungs to determine if you can see tissue which looks like cancer so that you can biopsy it; is that right?

A. Yes.

Q. Now, when -- Well, when Mr. Lucier had his bronchoscopy done, do you recall, was Dr. Lamb the bronchoscopist.

A. Yes.

Q. Do you recall whether Dr. Lamb was able to visualize any tissue that he thought was tumor?

A. We can refer to Dr. Lamb's notes, but I think the conclusion, if I recall, was that he did not see any adenobronchial tumor.

9041

Q. He did biopsy some tissue from the lung; is that right?

A. Correct.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

4 Q. And that tissue was not diagnostic for cancer?

5 A. That is correct.

6 Q. So then, because you wanted to figure out what this

7 mass was in the hilar region, you had Mr. Lucier undergo a

8 mediastinoscopy?

9 A. That is correct.

10 Q. And now explain to me briefly what a mediastinoscopy

11 is.

12 A. A mediastinoscopy is above your collarbone or the

13 clavicle, and usually on the right side. You go and make a

14 small incision about the size, half an inch or smaller, and

15 introduce a rigid scope with fiberoptics built in, and the

16 channel built in to take the tissue out.

17 And you go, like parallel to your windpipe or

18 trachea, and look at the tissue and grab some biopsy

19 specimens and bring it out.

20 Q. Does the mediastinoscopy go into the lung?

21 A. It will be outside the lung. It will not be in the

22 substance of the lung.

23 Q. Okay. So when Mr. Lucier had his mediastinoscopy,

24 the mediastinoscope scope -- Is that the right term?

25 A. Um-hum.

26 Q. -- Went into the mediastinum but not into the

27 substance of the lung?

28 A. That is correct.

9042

1 Q. And the biopsies that were taken during the

2 mediastinoscopy were not taken from the substance of the

3 lung?

4 A. That is correct.

5 Q. The tissue taken during the mediastinoscopy was

6 eventually diagnosed as cancer; is that right?

7 A. Yes.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

8 Q. Do you remember what type of cancer it was diagnosed

9 as?

10 A. I think it was poorly or undifferentiated cancer --

11 Poorly or undifferentiated cancer. But we can look into the

12 report which I have here.

13 Q. You have the pathology report in front of you?

14 A. Yeah.

15 Q. That's part of the -- Just for the record, that's

16 part of the exhibit?

17 A. Let me see if that's the right one.

18 It's part of the Exhibit No. 4, and it's in the

19 report dated 6/21/99.

20 Q. Okay. Does that help refresh your recollection of

21 what his cell-type diagnosis was?

22 A. It was metastatic large-cell carcinoma with --

23 Q. Mucicarmine?

24 A. -- Mucicarmine positivity, consistent with poorly

25 differentiated adenocarcinoma.

26 The spelling of mucicarmine is M-U-C-I-C-A-R-M-I-N-E.

27 Q. So the ultimate diagnosis was -- First of all, it

28 was metastatic large-cell carcinoma?

9043

1 A. Right. Or non-old cell-type carcinoma.

2 Q. And when you say metastatic, it means that the tissue

3 that the pathologist was looking at was likely not from a

4 primary cancer? Is that right?

5 A. Because the mediastinoscopy creates a biopsy or

6 performs biopsy of lymph node.

7 Q. Okay.

8 A. And it was not a marked a lymph-gland tumor, so it

9 came from somewhere else. So that's why he infers the term

10 "metastatic", because the tumor that was found in the lymph

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

11 gland was not originating in the lymph gland or lymph

12 substance itself. It came from some other organs in the

13 body.

14 Q. Okay. Let me ask two questions about pathology.

15 During the time when you treated Mr. Lucier, did you

16 ever take pathology or did a pathologist ever observe

17 pathology from an organ that he considered the primary

18 tumor?

19 A. No. He just got the tissue from the mediastinum.

20 Q. Okay. And I take it also, then, that the -- Maybe I

21 know the answer to this question, but let me ask it anyway.

22 Was tissue diagnostic for cancer ever taken from

23 Mr. Lucier's lung?

24 A. No.

25 Q. What prognosis did you have for Mr. Lucier at the

26 time you treated him?

27 A. It would be poor, you know. It will be in terms

28 of -- We still hadn't completed -- Or unless you want me

9044

1 to review the report -- How much was the metastatic workup

2 completed -- It's described in my discharge summary.

3 Q. I don't want to cut you off, but if you have

4 something from the discharge summary that you feel is

5 relevant, sure, let's -- (pausing)

6 A. With his diagnostic staging that Dr. Collins had

7 made, it was thought to be stage IIIB lung cancer -- You

8 can write Roman III and B like 'boy' -- Lung cancer, with

9 the involvement of subcarinal, pretracheal and mediastinal

10 lymph nodes.

11 MR. BROWN: Okay. So you were reading from the final

12 diagnosis; is that what you were doing?

13 THE WITNESS: Right, that he did have stage IIIB, you

14 know, cancer.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

15 MR. BROWN: And that's a lung cancer?

16 THE WITNESS: Yes.

17 MR. BROWN: Okay.

18 THE WITNESS: Yes. It is now, because we did the --

19 You know, there was nothing else we could correlate, so we

20 put stage IIIB. And I am sure Dr. Collins must have made,

21 in her notes somewhere, the mention, because usually final

22 staging is done by the oncologist.

23 Q. BY MR. MURPHY: Dr. Collins would be the oncology?

24 A. Right.

25 Q. And if it wasn't Dr. Collins, I think another

26 oncologist that Mr. Lucier saw, because Dr. Collins was on

27 vacation, was Dr. Jaffee, is it?

28 A. Julius Jaffee.

9045

1 Q. And the oncologist is usually the one who would do

2 the staging?

3 A. Usually.

4 Q. So that stage IIIB lung cancer probably came from the

5 oncologist and not you?

6 A. Possibly.

7 Q. Why -- If it was you, why would you have called

8 Mr. Lucier's cancer a lung cancer?

9 A. Oh, it was adenocarcinoma --

10 Q. Okay.

11 A. -- With involvement of the hilum, mediastinum and

12 pretracheal area.

13 And, most likely, probably, you know -- You know,

14 probably it originated in the lining of the hilum or the

15 windpipe or trachea -- Or bronchus.

16 So it will fit more with like a clinical impression,

17 but we did not have any biopsy of the lung, you know, if

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

18 you're referring to that. As far as the lung itself, at

19 that point, did not have -- At the time of discharge

20 summary, did not have a cancer that we proved.

21 Q. You had a clinical impression of the primary cite of

22 the cancer?

23 A. Correct.

24 Q. And that was the lung, right?

25 A. Right.

26 Q. But you couldn't make any diagnosis of cancer in the

27 lung because you didn't have pathology from the lung?

28 A. That is correct. But -- And we did not have from

9046

1 the hilum because we had only the mediastinum biopsy. The

2 hilum is difficult to approach --

3 Q. Okay.

4 A. -- Unless you open up the chest, or you do a

5 thorascopic procedure -- T-H-O-R-A-S-C-O-P-I-C -- procedure,

6 it could be hard to prove that.

7 Q. And you didn't go ahead and do that type of procedure

8 because it wasn't necessary in order to properly treat

9 Mr. Lucier; is that right?

10 A. That is very correct.

11 Q. Whether his cancer was of the hilum or not, the

12 treatment he received would have been appropriate?

13 A. Correct.

14 Q. Dr. Mehta, can you tell from your records when the

15 last time it is that you saw Mr. Lucier?

16 A. 6/22/99.

17 Q. And at that time you would have turned his care over

18 to his oncologist?

19 A. That is correct.

20 Q. And I'm not sure if we got an answer or not when I

21 said, in general, what was his situation like when you

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.tobaccoindustrydocuments.ucsf.edu/docs/kzgl0001

22 turned him over to his oncologist?

23 A. Well, situation like this will probably go maybe from

24 few weeks to maybe year and a half, you know, at the most, I

25 would guess -- Because he had, you know, metastatic

26 disease. And I think that's a good guess about the

27 longevity of his life.

28 Q. Do you know, for example, if Mr. Lucier is alive or

9047

1 not today?

2 A. I do not know about that. I would like to know.

3 Q. Well, he's alive. Does that surprise you?

4 A. He -- Then it does surprise me with that advanced,

5 unless it was a lymphoma, you know.

6 Or sometimes small-cell cancer, very small

7 percentage, you know, of stage IIIA, IIIB, maybe two to five

8 percent, they could be alive at five years of this degree.

9 But 95 percent will be gone, you know, like within -- Like

10 within timeframe we talked about.

11 But stage IIIA, IIIB, about less than five percent

12 could be alive at, you know, five years.

13 Q. Okay. In any event, survival for this long is not

14 typical for patients who suffer from adenocarcinoma of the

15 lung?

16 A. For the most patients, but there is very definitely a

17 small percentage, as I mentioned, five percent or less, that

18 could be alive.

19 Q. That's true for adenocarcinoma as well?

20 A. Adenocarcinoma has higher mortality. Small-cell also

21 has a higher. Squamous cell is a good possibility that it

22 can be brought under control.

23 Q. So for adenocarcinoma, it would be even less than

24 five percent?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

25 A. It would be less than that.

26 Q. Now, you know, I take it from your subpoena and from

27 who I represent that Mr. Lucier has sued tobacco companies,

28 claiming that his cancer was caused by smoking.

9048

1 Are you aware of that?

2 A. I just learned when I received the subpoena.

3 Q. Okay. After going through all these medical records,

4 do you now recall Mr. Lucier?

5 A. Yes.

6 Q. Just your recollection of him?

7 A. Oh, he seemed very, you know, like -- I remember

8 him. I remember when he was -- I think in room 364, bed

9 one, and he stayed in that room. And I remember talking to

10 his wife. And he was -- I think I would say that he was an

11 intelligent person.

12 Q. All right. And so as of the time of the final

13 discharge summary, if I'm reading this correct, it says,

14 "Final diagnosis: Number one, stage IIIB lung cancer with

15 involvement of subcarinal --

16 A. Carinal. (pronunciation)

17 Q. Carinal.

18 A. Carinal.

19 Q. -- "Carinal, pretracheal, and mediastinal lymph

20 nodes."

21 Did I read that right?

22 A. Yes.

23 Q. And that's the final diagnosis you put down?

24 A. That's where I put it.

25 Q. What were the factors that led you to write into this

26 discharge that the final diagnosis was lung cancer?

27 MR. DUNCAN: Objection, asked and answered.

28 THE WITNESS: The -- After, you know, the diagnostic

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

1 workup, in this case we did not obtain tissue from the lung.

2 Q. BY MR. BROWN: No?

3 A. -- Which may not be possible in all cases. And the

4 mediastinoscopy was done --

5 Q. Um-hum.

6 A. -- Which gave the diagnosis.

7 So presumption would be that most likely it would be

8 stage, you know, IIIB or advanced lung cancer with

9 involvement of the hilar mediastinal, pretracheal

10 subcarinal, and all of these lymph nodes.

11 Q. Why would it be most likely lung cancer, given the

12 workup that you had.

13 MR. MURPHY: Objection to the form.

14 THE WITNESS: Well, because we didn't have maybe a

15 lot of evidence of cancer in the abdomen OR pelvis or other

16 parts of body.

17 Q. BY MR. BROWN: Okay.

18 A. And since lung cancer is more common cancer, you

19 know, you may consider that most likely it were lung cancer.

20 If one were to give treatment, you can consider maybe on the

21 basis of lung cancer.

22 Q. Okay.

23 A. But it is not -- If -- You know, maybe Dr. Collins

24 or Jaffee, may be appropriate, you know, people to say,

25 because --

26 Q. I'm just asking you why you wrote that?

27 A. I did the discharge summary. But I would say that,

28 because there was no stomach cancer or colon cancer or

1 kidney cancer.

2 Q. Um-hum.

3 A. So it was more like a presumption, but we didn't do

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

4 lung biopsy.

5 Q. Let me go down to point 5.

6 Well, first before I do that, what is stage IIIB?

7 A. Um, in stage I and II, the cancer -- The cancer

8 would be like, cancer would be in -- Confined to the lung.

9 In stage IIIB, it will be like involvement of the

10 nodes in the mediastinum, IIIA and IIIB.

11 Q. From a metastasis?

12 A. Or from a metastasis, from lung cancer.

13 Q. All right. Somewhere -- And I'm not sure if it's in

14 this document or not -- This cancer is referred to as a

15 metastasis.

16 I don't find it in this document. But do you

17 remember that in some of the earlier documents?

18 A. Well, there are lymph nodes, so lymph nodes are

19 tumor. And it's not a lymph-node-type tumor. So there is a

20 tumor in the lymph node.

21 But, you know, like going back to, since you are

22 asking me the question, makes me think that it is presumed,

23 but there was no, you know, cancer on the CAT scan or the

24 bronchoscopy biopsy proving that this was coming from the

25 lung. So that makes me think now, because I didn't follow

26 the patient for a long time, that it's possible that the

27 origin of the tumor would be in other parts of the body

28 tissue --

9051

1 Q. Sure.

2 A. -- That could have metastasized to those lymph

3 nodes. And if -- If nothing showed up until to date, maybe

4 the origin is something different or maybe it was lung and

5 got treated. And I didn't do long-term follow-up. So --

6 Q. Sure. All right. You led me right into my next

7 question.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

8 I want you to assume that as of today -- And Mr.
9 Lucier is still alive -- That other than a metastasized
10 tumor to the brain, there has been -- No other cancer has
11 been found in any other part of his body. Assume that.
12 A. Um-hum.
13 Q. Would that strengthen the opinion that you put down
14 here in the discharge summary that this was a lung cancer?
15 A. It would not, because there are some cancers that I
16 have seen over the course of my practice years that have no
17 primary that we could identify.
18 It seems that it happened in this particular case.
19 Q. On the day that you wrote this document -- That's
20 all I'm asking, where you put down stage IIIB lung cancer --
21 On that day it was your belief that it was a lung cancer;
22 would that be correct.
23 MR. MURPHY: Objection as to form.
24 MR. DUNCAN: Objection; asked and answered.
25 THE WITNESS: On that day, it was thought that it was
26 lung cancer with mediastinal or lung cancer, you know, as
27 the origin. But again the workup was not all complete as
28 far as --

9052

1 Q. BY MR. BROWN: Are you aware of any fact or anything
2 which has developed in Mr. Lucier's case since the date that
3 you prepared this document which could indicate that it's
4 not lung cancer?
5 A. I have no information on his case.
6 Q. Okay. Now, there were some other areas of the body
7 that I think there were some suspicion, not whether you were
8 asked, but whether it's possible that it could be cancer or
9 is it possible that this could be cancer or a tumor. Let's
10 see, if we can go through these.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

11 There was the spleen, for example. Now, more likely
12 than not, doctor, if there had been a tumor in his spleen in
13 1999, but as of right now it is not detectable, would that
14 indicate to you that there was no tumor in the spleen in
15 1999?
16 MR. DUNCAN: Objection. Lack of foundation.
17 THE WITNESS: Did he get any chemotherapy?
18 Q. BY MR. BROWN: Yes, he did.
19 A. Radiation therapy?
20 Q. Radiation on the lung.
21 A. No operation or surgery?
22 Q. No.
23 A. So spleen could have been either infarction, because
24 cancer patients do have hypercoagulable state, and he did
25 manifest pulmonary embolism on the CT pulmonary angiogram
26 which was performed at Memorial Hospital.
27 So spleen, a splenic artery, or portion of the artery
28 or branch of the artery could have been developed a blood
9053
1 clot, and that's why we saw the infarction. And so -- And
2 that, as of the repeat scan was done in few weeks, it would
3 clear up because an infarction gradually, like a wound, it
4 would heal.
5 Q. Okay.
6 A. And it will clear and up may or may not leave any
7 scar.
8 And the same thing is true for the kidney.
9 Q. I'm not sure my question got addressed directly at
10 least.
11 Would you agree that it's more likely than not that
12 if there had been a tumor, if that possibility of a tumor
13 was in fact correct back in 1999, in the spleen, that by now
14 it would have become detectable?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

15 MR. MURPHY: Objection to the form.

16 THE WITNESS: No, because if the patient received

17 chemotherapy, like it will bring cancer under control,

18 potentially it will bring cancer -- If there's a cancer

19 spot in the spleen, that would also come under control.

20 Q. BY MR. BROWN: If there had been no detectable tumor

21 detected in the kidney as of now, would that indicate to

22 you, more likely than not in 1999, there was no tumor in the

23 kidney?

24 A. I think the answer would be similar to given for the

25 spleen; that may be more likely to be infarction than tumor.

26 But patient received treatment, so it's hard to know. Both

27 can disappear at times if they're responsive to the

28 treatment.

9054

1 Q. Um-hum?

2 A. So if patient had metastatic tumor, got chemotherapy,

3 and then the timeframe for -- If the other lymph nodes

4 dissolved or resolved or reduced in size, like in the kidney

5 or spleen areas, reduced in size too -- So it would be hard

6 to know for sure that, you know, if it was tumor process or

7 infarction. And irrespective of tumor or infarction, it

8 would not correlate what would have been the primary process

9 of cancer.

10 Q. As of the date that you filled out this document and

11 called it lung cancer, tell us what factors led you to the

12 conclusion for that date.

13 MR. MURPHY: Objection to the form.

14 MR. DUNCAN: Objection; asked and answered, I think

15 it's three times now.

16 THE WITNESS: At the time of the patient, some other

17 factors also play A role. But that at the time of the

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

18 discharge, you know, you do make some diagnosis. But that

19 could change with time.

20 He had hilar mass on the CAT scan, which was

21 three-by-four centimeters approximate size.

22 MR. BROWN: Okay.

23 THE WITNESS: Patient had pre-carinal nodes,

24 subcarinal nodes, mediastinal lymph nodes. There were

25 findings of hypercoagulability --

26 You're okay with word that, right?

27 MR. DUNCAN: Right.

28 THE WITNESS: -- Hypercoagulation or

9055

1 hypercoagulability, showing the evidence of pulmonary

2 embolism.

3 So those facts, those kinds of findings are seen

4 with, you know, rapidly advancing and metastatic disease.

5 And with a large hilar mass, you know, lung cancer was

6 considered, you know, at the time of dictation. But I don't

7 know what, you know, came in the future as far as further

8 workup, or if patient had any positron emission from

9 tomography or PET scan done that showed some spots in the

10 body. I'm not sure about that.

11 Q. BY MR. BROWN: Let me ask you this. If that right

12 hilar mass was a carcinoma, would that be, medically be

13 considered a lung cancer?

14 A. Maybe the question can be deferred to an oncologist,

15 but it is -- Even metastatic tumor can present, or by

16 lymphatics, in other lymph glands. Hilar is more likely to

17 be associated with lung cancer than mediastinal or, you

18 know, subcarinal. But if you want to be really like

19 purist -- And it may not be easy to prove, as far as, you

20 know, if you're really looking for 100 percent proof, then,

21 you know, we really need a tissue diagnosis from lung.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

22 But it is safe or it is reasonable for all the

23 purposes of treatment, because the treatment would not

24 change, you know, if there's a metastatic tumor of certain

25 type.

26 So we as physicians may not go into all the details

27 to find out, you know, where the origin of the cancer is.

28 But if the question is: Does the patient have tumor

9056

1 substance in the lung? We haven't, you know, proven that.

2 So -- It's so tricky.

3 Q. Are you saying that a right hilar mass is consistent

4 with lung cancer?

5 MR. MURPHY: Objection to the form.

6 MR. DUNCAN: Incomplete hypothetical. Objection,

7 incomplete hypothetical.

8 THE WITNESS: What I would like to say that odds are,

9 that as far as it being lung cancer, chances are very high

10 that it being primary lung cancer, and maybe there's a small

11 focus of lung that we cannot see or prove. But can other

12 cancer present like this?

13 If you are raising that question, it is surely

14 possible that other cancers could manifest within the

15 different lymph nodes in the body.

16 Q. BY MR. BROWN: So this final diagnosis was your

17 clinical diagnosis?

18 A. At the time of discharge after one week of treatment

19 in the hospital.

20 Q. And you apparently didn't have a differential

21 diagnosis?

22 A. At that time, I did not see the need to, you know,

23 well define, because he was going to be in the hands of two

24 good oncologists, Dr. Collins and Dr. Jaffee.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

25 Q. But if you had had a differential diagnosis, you

26 would have put it in this final diagnosis, wouldn't you?

27 MR. MURPHY: Objection to the form?

28 THE WITNESS: Not necessarily.

9057

1 Q. BY MR. BROWN: Not necessarily?

2 A. Well, I did not put -- If I did not put significant

3 amount of weight on that part because I was not only giving

4 treatment in the form of chemotherapy or radiation therapy,

5 I initiated -- I happened to be on call, admitted the

6 patient and initiated the workup, and then requested

7 Dr. Collins, who came within a day or two. And then, to

8 some extent, she would be steering and leading the case.

9 So I'll be completing all the paperwork and

10 formalities and you know, summary, like I have done. But a

11 lot would depend on Dr. Collins and Dr. Jaffee as far as

12 concluding as far as what is final diagnosis and treatment.

13 Q. Would you expect the oncologists who took over from

14 where you left off to give some importance to your final

15 diagnosis, or give some weight to it?

16 A. I would expect them to make -- Let me take it back.

17 My role would be to do diagnostic workup, use my

18 skills as with procedures, you know, like bronchoscopy,

19 thoracoscopy, and, you know, biopsy of the tissue masses,

20 and then I would let them do more workup, diagnostic workup,

21 and go with the clinical course in next few days, to few

22 weeks, to few months, and sometimes few years, and make the

23 diagnosis. Because I hope they don't rely, you know, to

24 some extent, on my final diagnosis. I hope that they make

25 an independent diagnosis themselves.

26 Q. Okay. Let me ask you this: As of time that he was

27 discharged and you wrote this final discharge summary, did

28 you have any evidence of a primary site for a cancer, other

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

than the lung?

MR. DUNCAN: Objection.

THE WITNESS: Not on CT scan of the chest, abdomen and pelvis he had, and not on physical exam.

Q. BY MR. BROWN: As of the time you discharged Mr. Lucier, had you done any testing that would have definitively ruled out another primary site of cancer?

A. Only workup he had, I believe, was CT of the abdomen and pelvis when he came. That showed us that spleen spot and that kidney spot.

Q. Right.

A. But we hadn't done like any workup on other organs like prostate and pancreas and, you know, colonoscopy or gastroscopy. No other workup was done at the time of his discharge, so no.

Q. So could you definitively rule out any site at a primary site for his cancer at the time of his discharge?

A. Because the workup was not completed yet, it would be hard to, you know, rule it out for sure. And for the treatment purpose, it did not matter -- At least in my opinion. But an oncologist would make a final decision.

Q. I have one further question, and I want to make sure that I understand your answer.

Are you saying that if you went back today and had to rewrite your diagnosis at his discharge, you would not list that as lung cancer?

A. It did make me think that discussion we had in last three hours that -- If I were to write it again, I would

say that I would -- I would say one of two things, depending on, you know, what other doctors who were working along with me feel.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

4 I would say metastatic cancer of primary etiology
5 unknown or at least needs to be established as an
6 outpatient.
7 Or I would say metastatic cancer, most likely from
8 lung, but other organs cannot be ruled out for sure, pending
9 further workup and clinical course in next weeks to few
10 months.
11 THE COURT: Okay, we'll take a five-minute recess.
12 Please don't discuss the case.
13 (A brief afternoon recess was taken at 3:57 pm.)
14 ---o0o---
15 THE COURT: Okay how long will this next deposition
16 take?
17 MR. GORDON: About 20 minutes.
18 THE COURT: And that will be it for today, right?
19 MR. GORDON: Yes, it will.
20 MR. PAUL: That will be it for sure.
21 THE COURT: Okay, bring them in.
22 (The jurors are returned.)
23 THE COURT: Okay, Mr. Grossman.
24 MR. GROSSMAN: Thank you very much, your Honor.
25 The next videotape deposition, about 20 minutes long,
26 is Dr. Bruce O'Neil, another plaintiff's treating physician,
27 taken on November 26th, 2001.
28 THE COURT: Okay.
9060
1 TESTIMONY OF
2 BRUCE O'NEIL, M.D., a witness called by Defendant RJR:
3 EXAMINATION
4 (As played via videotape)
5 Q. Dr. O'Neil, I'm Chris Johnson; I introduced myself a
6 few minutes ago.
7 Could you state your name and address for the record

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

8 for me.

9 A. My name is Bruce O'Neil, M.D., physician in Alameda

10 County, State of California. The address where I practice

11 is 2700 International Boulevard, Oakland, California.

12 Q. And you're licensed in California?

13 A. Yes.

14 Q. And since what date were you licensed in California?

15 A. 1968.

16 Q. So, could you describe your medical practice here for

17 me briefly.

18 A. Mainly composed of internal medicine, cardiology and

19 complicated medical problems, pulmonary, diabetes.

20 Q. Okay.

21 A. And the bulk of it is in cardiology. Cardiovascular

22 disease.

23 Q. Are you a primary care physician?

24 A. I do some primary care, as well as some specialty

25 work.

26 Q. When did you first become involved with the care of

27 Mr. Lucier? It's in the medical records?

28 A. I'd have to refer back to the record.

9061

1 The first visit was on September 22nd, 1997.

2 Q. Okay. And how did you become involved with Mr.

3 Lucier's -- How was he referred to you, or how did you

4 first encounter Mr. Lucier?

5 A. Well, I'm not sure. However, I took care of his

6 wife.

7 Q. And when was the last time you saw Mr. Lucier?

8 A. The last time you saw him was September 29th, 1997.

9 That's the last time I saw him.

10 Q. Okay.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
© Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

11 A. In the medical record it states, that on February
12 25th, 1998, that he had a sinus infection and we gave him a
13 prescription for medication. But that was probably over the
14 phone. There was no face-to-face contact.
15 Q. Any other telephone conversations with him?
16 A. No.
17 Q. Were you his primary-care physician for a time? For
18 that short time?
19 A. Probably.
20 Q. So what was Mr. Lucier's complaints when he -- That
21 brought him into your office in September of 1997?
22 A. He had low-grade fever for about two weeks.
23 Q. Um-hum?
24 A. And he had some headaches.
25 Q. Did he complain of cough?
26 A. No.
27 Q. Chest pain or shortness of breath?
28 A. I do not have that in the medical record.
9062
1 Q. Okay.
2 A. As far as I can see, he didn't.
3 Q. Any other complaints?
4 A. Well, essentially I asked him about his cough. He
5 denied any cough. He denied any rash. There was no weight
6 loss. There were no myalgias. The rest of the review of
7 systems essentially was negative at that time.
8 Q. Okay. And -- One second.
9 So at the time of that first treatment, what medical
10 history information did you obtain from him?
11 A. A past medical history was negative. The surgical
12 history, he had three laminectomies. Evidently this was
13 done in the East in the 1980s for a ruptured disk.
14 He was not taking any medications. He smoked one

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

15 pack of cigarettes daily. There was no history of

16 alcoholism.

17 He had a family history that was fairly unremarkable,

18 although his mother died of a stroke at the age of 67. He

19 had no diabetes.

20 That was the extent of the history.

21 Q. Okay. And you said one pack per day. Was that as

22 reported from him?

23 A. Yes.

24 Q. And why do you gather information on smoking history?

25 A. I -- It's -- I always ask this of all patients.

26 Q. And do you gather smoking history because it causes

27 certain diseases, like lung cancer, C.O.P.D., cardiovascular

28 disease?

9063

1 A. Yes. It's a risk factor.

2 Q. It's a risk factor?

3 A. So I always ask about various risk factors. Smoking

4 is one of them.

5 Q. And you mentioned risk factor instead of cause. Is

6 there a particular reason why you mentioned that?

7 A. Well, controversy, regarding all these matters.

8 Q. Okay. Based on epidemiological studies of

9 populations, risk factors are developed from epidemiological

10 studies?

11 A. Yes.

12 Q. Is that what you're referring to?

13 A. Pardon?

14 Q. Is that what you're referring to as risk factors?

15 A. Yes.

16 Q. Do you caution your patients to stop smoking, your

17 smoking patients to stop smoking?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

18 A. Yes.

19 Q. Is that also regular practice for you?

20 A. It's a regular part of the practice.

21 Q. And since what time has that been a regular part of

22 your practice?

23 A. Thirty years.

24 Q. And when you caution your smoking patients to stop

25 smoking, do you tell them why they should stop smoking?

26 A. Yes. I tell them basically what the risks are.

27 Q. Such as?

28 A. Heart disease, cancer of the lung, emphysema, chronic

9064

1 bronchitis.

2 Q. And what was your final impression with Mr. Lucier?

3 A. On the initial visit, I didn't have one. It was

4 unclear why he had a fever.

5 Q. Okay. Did you do follow-up studies?

6 A. Yes. We did. At the initial visit we did some basic

7 laboratory work, composed after C.B.C. or a complete blood

8 count.

9 Q. Um-hum.

10 A. We did a sedimentation rate. We did a urinalysis.

11 We did a complete chem panel, which included basic metabolic

12 panel, as well as liver-function studies.

13 We also did a P.S.A., which is a test for prostate

14 disease. And we did a T.S.H., which is a study to determine

15 the state of thyroid function.

16 And subsequent to some abnormalities in the liver-

17 function studies, we also did a hepatitis panel, which

18 basically looks for evidence of viral hepatitis.

19 Q. Okay.

20 A. And a chest x-ray.

21 Q. Let's start with the chest x-ray.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

22 Why was that obtained?

23 A. In general, when I'm working or evaluating a fever,

24 I'll get a chest x-ray, because we're looking for diseases

25 of the chest, such as pneumonia or bronchitis. So this was

26 the reason for the study.

27 Q. Okay. Which what was the result, or what did that --

28 A. The result was a normal chest x-ray, and the date of

9065

1 the test was 19/22/97.

2 Q. Okay. But let me show you the page ending in Bates

3 stamp number -0010.

4 A. Yes, I'm looking at it.

5 Q. And it continues on page -- I'm sorry -- I believe

6 the first page is -0009.

7 Could you read for me what those are that are out of

8 range?

9 A. These were liver-function studies. It was a G.G.T.

10 There was an S.G.O.T. or A.S.T., A.L.T. or S.G.P.T. These

11 are liver enzymes.

12 They're abnormal. They're elevated.

13 Q. And there's one other one, just for the record,

14 that's a bit higher?

15 A. Oh, that was a glucose; that was high at 129. That

16 was minimally elevated.

17 Q. Okay. So the liver enzymes, are those what you were

18 referring to when you said some of them looked abnormal, so

19 you followed up with the hepatitis screening?

20 A. Panel, yes.

21 Q. And the hepatitis panel was negative, did you say?

22 A. Yes. There was no evidence of any viral hepatitis.

23 Q. What else might cause these abnormal liver-function

24 tests?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

25 A. Well, any acute infection disease of the liver could

26 cause this. Also toxicity of the liver. There are many

27 drugs that can cause toxicity. Alcohol can raise these

28 values as well.

9066

1 Tumors can elevate these levels.

2 Q. Here it also mentions cholesterol is -- Actually

3 it's hard for me to make that out.

4 A. The cholesterol at the time was 232 milligrams per

5 deciliter, slightly elevated.

6 Q. Okay. And triglycerides?

7 A. The triglycerides were also elevated.

8 Q. And what is that number?

9 A. These are fatty substances.

10 Q. I mean how high was it?

11 A. It was -- Let's see -- 1057 milligrams per

12 deciliter, considerably elevated.

13 Q. What's the normal range there, just for the record?

14 A. The normal range is 47 to 175.

15 Q. So that's quite a bit out of --

16 A. It's quite elevated.

17 Q. -- Normal.

18 Let's flip to the next page, if I could, page ten,

19 ending in -0010, and go through some of the C.B.C. It looks

20 like there's a few low and a few high.

21 A. He was slightly anemic at 13.3 grams. And the other

22 parameters just reflect that.

23 Q. Okay. And what might cause slightly anemic state?

24 A. Well, there's a host of things. There's a long list.

25 Q. Okay.

26 A. Could be minor blood loss.

27 Some people have hemorrhoids, and they may lose a

28 little bit.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

9067
1 And then the list goes on and on. So at this level
2 it's rather non-specific.
3 Q. Okay. Anything that causes the liver-function
4 tests -- Anything that causes the liver-function tests, do
5 they have anything in common, common etiologies or common
6 causes that could raise both of those or throw both of those
7 off?
8 A. Well, there is. If somebody was drinking, say,
9 fairly heavily, they might have a minor chronic gastritis.
10 They could have a gastric ulcer caused by the alcohol.
11 They would also raise the liver enzymes, because they
12 were having problems with ethanolic hepatitis. So that's
13 one that comes to mind that's, you know, fairly common.
14 Q. Was he inspected to lower his cholesterol levels?
15 A. The last time I saw him on September 29th, 1997, I
16 advised him to reduce his cholesterol in his diet.
17 Q. And that's, I think, reflected here on page -0006.
18 A. Correct.
19 Q. And is that what -- What is that that you're looking
20 at, -0006?
21 A. Pardon?
22 Q. What is that? What is that? Do you recognize that
23 page?
24 A. Yes, I do.
25 Q. Is that the same as what's in your chart there?
26 A. Yes, it is.
27 Q. Okay. So that's one of the medical records that
28 you've turned over to us?
9068
1 A. Yes.
2 Q. And what does it say here on the right-hand column
3 about halfway down?

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

4 A. I planned to do a hepatitis screening panel at that
5 visit, which is September 29th, 1997. I also advised him to
6 reduce the cholesterol in his diet and stop smoking.
7 Q. Okay, "DC cigs", that means to stop smoking?
8 A. Yes.
9 Q. And likewise, with your recommendation to stop
10 smoking, we went over some of these reasons earlier?
11 A. Yes. I consider it a risk factor for cardiovascular
12 disease.
13 Q. And was Mr. Lucier told about the risks of cigarette
14 smoking?
15 A. I have nothing in the records to suggest that I
16 advised him of all the details.
17 Q. Is there any reason you would deviate from your
18 normal practice in this case?
19 A. No.
20 Q. And I think you stated earlier, normal practice is to
21 recommend to smoking patients to stop smoking and to warn
22 them of the risks of smoking?
23 A. Yes.
24 Q. What was your overall impressions then, after the
25 blood panel, the hepatitis panel, chest x-ray -- What was
26 your impression of the source of his fever?
27 A. I did not have any opinion. His -- He didn't
28 complain of any fever. He felt better. Initial impression
9069
1 was he looked okay. Reviewed the lab studies.
2 At that time, at September 29th, 1997, we still did
3 not have an answer as to why he had abnormal liver-function
4 studies.
5 At that time I wanted to get a hepatitis screening
6 panel. A hepatitis screening panel was collected on
7 9/29/97, two days after I had seen him for the second time.

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

8 Q. Um-hum.

9 A. So even at the second visit, I still wasn't sure

10 exactly what his problem was or why he had abnormal liver-

11 function studies.

12 After I checked the blood work for the viral

13 hepatitis studies, which was done on 9/29/97, I did not see

14 him again. He did not come back for a follow-up visit.

15 There's nothing in the chart that says, you know, we

16 called him, but normally when we find an abnormality or we

17 have test results that are significant, then we usually call

18 the patient. That's usually standard. So we might have

19 said to him, called him back and said that his studies were

20 normal, and it was just left at that.

21 Q. Do you believe, doctor, or did you believe in 1997

22 and 1998 that smoking was a cause of lung cancer?

23 A. I thought -- I think it's a risk factor in the

24 causation of cancer.

25 Q. Including lung cancer?

26 A. Yes.

27 Q. And when you advise a patient that it was a -- That

28 smoking, excuse me, was a risk factor in lung cancer, tell

9070

1 us, the best you can, what was your normal message? What

2 would you say?

3 A. Well, normally I tell somebody that if you smoke,

4 you're at a higher degree of risk of developing lung cancer.

5 So it's my advice that you stop smoking.

6 Q. All right. Let me go ahead to something else.

7 At the time that you saw him in 1997, did you see any

8 evidence of any serious disease?

9 A. What I found was that he had abnormal liver-function

10 studies, which subjected to me that he had some form of

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

11 hepatitis. But the etiology of this was unclear at the

12 time.

13 Q. All right.

14 A. My highest degree of suspicion was that he had

15 developed a viral hepatitis; however, my subsequent studies

16 did not confirm that.

17 Q. Any tests, any findings specific for excess use of

18 alcohol at the time that you saw him?

19 A. He had abnormal liver-function studies, which

20 generally can indicate that he had some sort of acute

21 toxicity or inflammatory process in the liver. One of the

22 etiologies could be excess alcohol, but that's only one.

23 And the tests that we did at that time were not specific --

24 Q. All right.

25 A. -- As to what the etiology of the abnormal

26 liver-function studies were.

27 Q. Okay. One more question about your normal warning,

28 your cigarette warning.

9071

1 As I understand it, you don't recall specifically

2 giving any warning to Larry Lucier; is that correct?

3 A. In the medical records of September 29, 1997, I

4 advised him to reduce his cholesterol in his diet, as well

5 as discontinuing cigarettes.

6 Q. All right. And that would indicate that you did --

7 You don't have a recollection of what you said, though, or

8 what?

9 A. I have it in the medical record to "DC cigarettes",

10 which is "discontinue cigarettes".

11 Q. Let me ask you what your normal warning is regarding

12 cigarettes, not just what you gave me before, but when you

13 warn a patient routinely about smoking, at least what you

14 did back in 1997, what would you say? Tell us as close as

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

15 you can, what you would say completely?

16 A. In general, if a person has been smoking or a has a

17 history of cigarette smoking, especially one pack of

18 cigarettes a day, I generally tell them that it's a risk

19 factor for cardiovascular disease and other cancer as

20 well -- There are other cancers as well, but generally lung

21 cancer and cardiovascular disease. So I usually recommend

22 that these people discontinue smoking.

23 MR. PAUL: Right on the dot.

24 THE COURT: Okay. We're going to take the recess

25 now, and we're going to recess until Tuesday. Tuesday at

26 10:00 o'clock in the morning.

27 Now, we've come a long way in this trial, and I am

28 going to take this opportunity, just at the risk of a few

9072

1 more minutes, to emphasize your responsibilities in the

2 trial as jurors.

3 I've told you each time we take a recess that you

4 must not discuss this case among yourselves or with anyone

5 else. That's very important; that's critically important.

6 Your responsibility as a juror is to keep an open mind, but

7 do not discuss any matter about anything that has anything

8 to do with this trial with any other juror or anyone else,

9 and do not permit anyone to talk to you about anything about

10 this trial.

11 That means that you shouldn't talk to other jurors in

12 the hallway, when you go to lunch. Even if you're in the

13 jury box there, you should not be saying anything about

14 anything that has anything to do with this trial. So keep

15 your comments to yourself; you'll have ample opportunity in

16 the jury-deliberation room to fully express yourself, when

17 we get to that point. But before that time, you must not

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

18 react to the evidence, you must not express any opinion.

19 Communication can take various forms. Just sit there

20 and listen to the evidence. Don't have a -- Don't react to

21 anything. You can react to yourself. Don't communicate to

22 anyone else anything about anything going on in the trial.

23 The first time that a juror may do that is when all 12

24 jurors are alone in that juror-deliberation room. And

25 you're to adhere to that rule very strictly. If you violate

26 that rule that's juror misconduct, and it can have

27 significant consequences.

28 So I'm just reminding you at this stage: You're not

9073

1 to form or express opinions in the case until this case is

2 finally submitted to you. That means keep an open mind.

3 Don't form any fixed opinions about things; listen to all

4 the evidence. You are not going to be in a position to form

5 meaningful opinions about this case until you've heard all

6 the evidence and recall the rules of law that apply to the

7 case. So I'm not going to say don't form or express an

8 opinion in the case. Again, that means keep an open mind.

9 Again, let me remind you not to read any media

10 accounts that may appear regarding this case. Don't read or

11 look at anything that has anything to do with what's going

12 on in this trial, any subject that may be in controversy.

13 You have to make your decision based on what you hear as

14 jurors in this courtroom and not from anywhere else. I'm

15 not trying to lecture you, but I do want to remind you of

16 these important responsibilities.

17 You've all been very attentive, and thank you very

18 much. Have a nice weekend. And we'll see you at Tuesday

19 morning at 10:00 o'clock. Thank you.

20 (The jurors depart the courtroom at 4:33 pm.)

21 ---o0o---

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

22 THE COURT: We're going to start tomorrow at 9:00

23 o'clock, right?

24 We going to finish up in the morning?

25 MR. PAUL: With that motion?

26 THE COURT: With that motion, right.

27 MR. PAUL: I would certainly hope so.

28 THE COURT: And then there are other things that you

9074

1 intend to take up?

2 One of the things that concerns me -- I guess we can

3 go off the record at this point.

4 (A brief discussion was held off record at 4:34 pm.)

5 ---o0o---

6 THE COURT: Let's go on the record for this.

7 Well, anyway, I want to put this on the record

8 anyway.

9 Mr. Barron, you won't be here tomorrow morning?

10 MR. BARRON: Yes, your Honor. I was just saying off

11 the record, unless there's some need for me to proceed --

12 And I've discussed with this co-counsel for the defendant --

13 I am not going to be here tomorrow. I actually lost a

14 filling, and I got a dentist who has worked on me before to

15 take me in at 9:00 in the morning. And I will have another

16 lawyer here representing Philip Morris's interests tomorrow.

17 As I understand it, the motion for nonsuit is a

18 motion by Reynolds, and we will comment in support of it,

19 that -- Only in the respect that we support their efforts

20 to get it on their own behalf.

21 We will have somebody here knowledgeable, I hope, on

22 the issue of exhibits, if that's what the Court intends to

23 take up.

24 And the other matter is the deposition yet to be read

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001

25 that needs to have objections resolved. And we're leaving

26 that essentially for co-defendant to resolve. But we'll

27 have, again, a lawyer here.

28 If there's something else that the Court thinks or

9075

1 any counsel thinks requires my presence as a lead lawyer,

2 I'll just have to make different arrangements. I'll try to

3 be here.

4 MR. PAUL: Can we go off the record again for a

5 second?

6 THE COURT: Everyone wants to go off the record?

7 MR. GROSSMAN: Sure.

8 MR. GORDON: Sure.

9 (A brief discussion was held off the record.)

10 ---o0o---

11 THE COURT: All right. Thank you. See you in the

12 morning.

13 (All say good night.)

14 ---o0o---

15

16

17

18

19

20

21

22

23

24

25

26

27

28

http://legacy.library.ucsf.edu/tid/jsq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/kzgl0001